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The Primacy of Politics: the rise and fall of evidence-based public health policy?

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Abstract

Over the last 20 years, there has been increasing reference to evidence within English policy circles both nationally and locally. However, in 2013, a series of national decisions about plain packaging, alcohol pricing, and the NHS Health Checks scheme, as well as the move of public health into local authorities, have acted as reminders of the long standing cultural differences between researchers and policy makers and the primacy of political priorities. This editorial reflects on these issues and concludes by discussing the future prospects of evidence-based public health policy and the normative relationship between evidence and politics in a democratic system.

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The Primacy of Politics: the rise and fall of evidence based public health policy?

This editorial reflects on the apparent rise and the potential fall of the use of evidence in English public health policy. Over the last 20 years, there has been increasing reference to evidence within policy circles both nationally and locally. However, in 2013, a series of national decisions about plain packaging, alcohol pricing, and the NHS Health Checks scheme, as well as the move of public health into local authorities, have acted as reminders of the long standing cultural differences between researchers and policy makers and the primacy of political priorities. This editorial reflects on these issues and concludes by discussing the future prospects of evidence based public health policy and the normative relationship between evidence and politics in a democratic system.

Since 1997, the role of evidence in policy making has increasingly been emphasised, at least rhetorically, by successive governments. For example, the ascendancy of evidence is apparent in a variety of government reports from the 1999 White Paper on *Modernising government* [1] to the 2011 public health White Paper *Healthy Lives, Healthy People* [2]. It was perhaps most evident in the establishment of the National Institute for Health and Care Excellence in 1999 which was initially just clinical in remit but then expanded to public health in 2005 and social care in 2013. This interest in evidence was reflected in an upsurge in public funding for evidence-based policy research [3] and academics were encouraged to produce the evidence required by policy makers to inform their decisions about the development and implementation of public health policy interventions [4].

Subsequently there was a massive increase in the volume of university research into the effectiveness of policies and interventions across public health and other policy domains. By way of example, a simple search in the social science part of Web of Sciences for “evidence-based policy” results in only 57 hits for the years 1869 to 1996 but 8742 hits for the years 1997 to 2013. The increased policy focus on evidence also helped underpin the emergence of a tentative public policy RCT base within the UK. Internationally, the EBP ‘movement’ was supported by a call from the World Health Organization (1998) [5] for ‘*an evidence-based approach to health promotion policy and*

practice' as well as the development of the Campbell Collaboration and the establishment of the Cochrane Collaboration public health group.

Yet, despite the rise in evidence rhetoric and all the accompanying research activity, most analyses conclude that research still plays a very limited role in public health policy [6]. Why? Writing as early as 1979, Caplan [7] identified institutional, cultural and communicative gaps between research producers and research users in policy and practice as the problem and the reason for a lack of real EBP. Certainly research into EBP in public health would confirm elements of this analysis with examples of differences over: (1) what constitutes 'good' evidence - with policymakers highlighting the importance of 'good stories' whilst researchers focus on controlling for bias [8][9]; (2) what evidence is 'needed' by policymakers - where policymakers emphasise timeliness and political relevance over quality [8]; and (3) how to deal with 'inconclusive' results - with researchers always wanting more research whilst waiting and *'doing nothing is not an option'* for policymakers [8].

However, there are clearly more than 'cultural differences' behind the evidence façade. Policy-network theory argues that it is the political 'relevance' of evidence which is the most important factor in whether it is heard, used, ignored or abused, with evidence that 'goes against' prevalent ideological imperatives or political priorities more likely to be marginalised [10]. In a democracy of course, decisions can never solely be made on evidence – they will be informed by ideology and values, public opinion and lobbying. There have been several prominent cases in public health in the summer of 2013 that really demonstrate this 'primacy of politics': minimum price for alcohol, plain tobacco packaging and NHS health checks.

In July 2013, the government announced that it had decided to scrap the proposed 40p minimum unit price for alcohol in England because there was *'not enough concrete evidence'*. This was despite strong economic modelling of likely effects and real-world evidence of effectiveness from Canada. There was huge press speculation about the influence of industry lobbyists on this decision. It may also have been influenced by more principled views about protecting personal choice. This was

accompanied by the shelving of plans to introduce plain packs for tobacco. The cited reason was that we need to '*see how it works in Australia*' but again; there was high speculation about the influence of industry lobbying. The third example from summer 2013 was the continued roll-out by Public Health England of the NHS Health Checks scheme because, whilst a Cochrane review [11] found no evidence that it was effective, '*there is nonetheless an urgent need to tackle the growing burden of disease which is associated with lifestyle behaviours and choices*'. These political aspects of national public health policy making are more likely to be replicated locally now following the move of public health responsibilities to local authority-led Health and Wellbeing boards in April 2013. This increases the democratic accountability of local public health - but it also introduces the potential pitfalls of party politics too.

So when it comes to the crunch, politics has primacy. This is not surprising but it perhaps poses a dilemma for those committed to EBP, as it limits the role of evidence in a democratic system. The pure EBP perhaps dreamed of by some in the movement, is unrealistic as it '*requires a linear relationship and is dependent on an unrealistically simple account of policy making*' [10] which would result in a mere technocracy of interpreting and implementing evidence. There is undoubtedly a need for principles, values, ideologies and struggle within any democratic process. Evidence should also be part of this, but politics will, and should, always be *ascendant*. Whilst this can be extremely frustrating on occasions for researchers – and this summer has been one of considerable discontent for public health - we can, and should, only ever aim for *evidence-informed* policy.

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